08. CENTE	108/2017 11:50 NH RS FOR MEDICARE	C-MRTCC 45+day 9	2-17/	70th 9-22-17	(FAX)931 840 4402		P.005/024 บย38-0391
TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI-R/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE COMP	SURVEY
DEC H	1 Fax	445030	B. WING			07/1	9/2017
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS,	CITY, STATE, ZIP CODE		190
MA MA	URY REGIONAL TRAI	NSITIONAL CARE CENTER		6010 TROTWOOD COLUMBIA, TN		×	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	ER'S PLAN OF CORRECTIO RRECTIVE ACTION SHOULD ERENCED TO THE APPROP DEFICIENCY)	DBE	(X6) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 000		¥		
	#40134 were compl NHC- Maury Region	vey and complaint 4, #39995, #40087, and eted on 7/17/17 - 7/19/17 at nal Transitional Care Center. ited related to complaint			8		
E 457	investigation #4008 and the recertification	7 and #40187 and were cited on survey under 42 CFR ments for Long Term Care	F 157	MD was noti	fied on patient #168	9	
SS=D			. 101		_	,	7/18/17
	consult with the resi	mediately inform the resident; dent's physician; and notify,		Fentanyl pate to ensure no	ed all patients on thes for placement evidence of tion r/t missing patc	:hes.	
(" -	consistent with his or representative(s) wh	or her authority, the resident nen there is-		Or failure to	notify MD		7/18/17
	(A) An accident invo results in injury and physician intervention	lving the resident which has the potential for requiring on;		all nurses reg	rse will in-service arding abuse and of MD /& DON		
	mental, or psychoso deterioration in healt	nge in the resident's physical, clai status (that is, a th, mental, or psychosocial treatening conditions or	٠	regarding clir	nical complications Coordinator or pharm	nacy	8/8/17
	clinical complications (C) A need to alter tr	eatment significantly (that is,		patches for ar	II QA 2 patients on f ny evidence of	fentanyl	
	a need to discontinu treatment due to adv commence a new fo	rerse consequences, or to		MD/DON is I Weekly x 4 w	tion and to ensure notified when appropeeks, then monthly	x3, then	
1	(D) A decision to trar resident from the fac §483.15(c)(1)(ii).	nsfer or discharge the lility as specified in		is met	ntil substantial com	рпансе	ongoing
ORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	,/ TY	TLE .	1	(6, wall - 7-17
deliclose	a datament and on with or	n asterisk (*) denotes a deficiency which	h the instituti	on may be excused	from correcting providing	It is determ	lned that
r safegua	ds provide sufficient prote	ection to the patients. (See instructions	.) Except for	nursing homes, the	findings stated above are	: disclosabl	e 90 days

If continuation sheet Page 1 of 11

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF .VCLIA DENTIFICATION NUMBER;		1 ' '	LTIPLE CONSTRUCTION DING	=	(X3) DATE SURVEY COMPLETED
a_{2K_1}	· #/W	445020	B. WING			07//0/2047
		445030	D. AAIMG			07/19/2017
	PROVIDER OR SUPPLIER URY REGIONAL TRA	NSITIONAL CARE CENTER		STREET ADDRESS, CITY, S 6010 TROTWOOD AVE COLUMBIA, TN 38401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHOUL		BE COMPLETION
F 157	(14)(i) of this sectionall pertinent informs	otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2)	F	157	8	
	physician. (ili) The facility must resident and the reswhen there is- (A) A change in root as specified in §483 (B) A change in resident.	vided upon request to the talso promptly notify the sident representative, if any, m or roommate assignment 1.10(e)(6); or dent rights under Federal or ions as specified in paragraph				
	(e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMEN by: Based on medical rethe facility failed to reside the section of the facility failed to reside the facility failed the fa	t record and periodically (mailing and email) and e resident representative(s). IT is not met as evidenced record review and interview notify the Physician of a for one resident (#168) of 3				
	was admitted to the diagnoses including Behavioral Disturbar Cerebral Infarction, A Deficit, Dysphagla, A	w revealed Resident #168 facility on 7/19/16 with Vascular Dementia with nce, Aphasia following Attention and Concentration unxlety, Depression, lity in Walking, Chronic Pain,		Facility ID: TN5005	If continual	ion sheet Page 2 of 11

P.006/024

(FAX)931 840 4402

08/08/2017 11:50 NHC - MRTCC

OBI	08/2017 11:51 NHC	- MRTCC & MEDICAID SE TICES			(FAX)931 840 4402	OWR NO	P.007/024). 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION		TE SURVEY MPLETED
		445030	B. WING	_		07	/19/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
-M		NSITIONAL CARE CENTER			5010 TROTWOOD AVE COLUMBIA, TN 38401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	COMPLETION DATE
F 157	Continued From pa		F1	57			
	Data Set dated 4/18	ew of the Quarterly Minimum 8/17 revealed a Brief Interview ould not be conducted nt was rarely/never			707		25
	Registered Nurse (F AM revealed "did no pain medication tran chest as documente	ew of a nurse note by RN) #1 dated 7/18/17 at 8:50 of find fentanyl patch [narcotic nsdermal patch] to R [right] ad. will ask on coming nurse If none found, to place					is 186
Ç	telephone revealed shift the night of 7/1 #168. Further intervifentanyl patch was Continued interview missing Fentanyl pa	ion 7/19/17 at 2:25 PM via she worked the 7PM to 7AM 7/17 and cared for Resident iew revealed she noticed the missing around 4 AM. revealed RN #1 reported the tch to Licensed Practical hift change and asked her to asn't found.					
	telephone revealed at AM to 7 PM and care interview revealed R the Fentanyl patch winterview confirmed I Physician of the miss to do so.	1 on 7/19/17 at 2:55 PM via she worked 7/18/17 from 7 ed for Resident #168. Further N #1 told her at shift change vas missing. Continued LPN #1 intended to notify the sing Fentanyl patch but failed					
F 225 SS=D	483.12(a)(3)(4)(c)(1) ALLEGATIONS/INDI	-(4) INVESTIGATE/REPORT VIDUALS	F 22	25			

08/08	1/2017 11:51 NH	IC - MRTCC		(FAX)931 840 4402	P.0	08/024
TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPI _R/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION	(X3) DATE SI COMPLE	JRVEY
		445030	B, WING		07/19/	2017
NAME OF PR	OVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE		
r()MAUE	RY REGIONAL TRA	NSITIONAL CARE CENTER		6010 TROTWOOD AVE COLUMBIA, TN 38401	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE CO	(X5) DMPLETION DATE
- 1	Continued From pa 83.12(a) The facil	_	F 2:	F225	i	
,	3) Not employ or o /ho-	therwise engage individuals		Patient #379 was discharged investigation complete on patie #168	nt	11/23/10 7/22/17
n 	xploitation, misapp nistreatment by a d	I guilty of abuse, neglect, propriation of property, or court of law; ng entered into the State		All patients reviewed for incide of unknown origin to ensure an		71 22/1 7
	urse aide registry	concerning abuse, neglect, atment of residents or		investigation was complete as indicated. All patients with MD order for Fentanyl patches were reviewed.	d to	7/18/17
01	her professional	ary action in effect against his license by a state licensure a finding of abuse, neglect,		ensure no evidence of misappro		7/18/17
e	xploitation, mistrea	atment of residents or resident property.		Regional Nurse will inservice all nurses regarding reporting of incidents and procedures		
lic	ensing authorities ctions by a court o	ate nurse aide registry or any knowledge it has of f law against an employee,		regarding missing fentanyl pato	hes	8/8/17
nt	irse aide or other	e unfitness for service as a facility staff. legations of abuse, neglect,		DON/ADON Team Coordinato will review incidents of unknow to ensure appropriate investigat	vn origin	
		eatment, the facility must:		is complete weekly x 4 weeks,		75
ab Ind mi rej aft ca	use, neglect, explicteding injuries of a sappropriation of ported immediately er the allegation is use the allegation.	leged violations involving oltation or mistreatment, unknown source and resident property, are y, but not later than 2 hours a made, if the events that Involve abuse or result in		monthly x 3, then quarterly or until subsaintal compliance is n DON/Team Coordinator or phase consultant will QA 2 patients or patches for any evidence of misappropriation and to ensure	macy	Ongoing
the		or not later than 24 hours if the allegation do not involve Dosolete Event ID:788Z11	ļ.	Facility ID: TN800B If continus	ition sheet Pag	e 4 of 11

08/	08/2017 11:51 N	IC - MRTCC		(FAX)931 840 4402	P.009/0	24
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPL CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	d.	445030	B. WING	NA CARREL TO AND	07/19/2017	
	ROVIDER OR SUPPLIER	NSITIONAL CARE CENTER	4	STREET ADDRESS, CITY, STATE, ZIP CODE 5010 TROTWOOD AVE COLUMBIA, TN 38401	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	ИС
F 225	the administrator of officials (including to adult protective ser for jurisdiction in lor accordance with Steprocedures. (2) Have evidence to thoroughly investigated.	esult in serious bodily injury, to the facility and to other the State Survey Agency and vices where state law provides ng-term care facilities) in ate law through established that all alleged violations are ated.		MD/DON is notified when appro Weekly x 4 weeks, then monthly quarterly or until substaintal com is met	x3, then	ing
	administrator or his representative and with State law, including Agency, within 5 would be alleged violated corrective action mutable. This REQUIREMENT by: Based on facility poreview, and interview investigate injuries of the pain patch for 1 resingular pain patch for 1 resingular patch for 1 re	to other officials in accordance dling to the State Survey orking days of the incident, and on is verified appropriate ust be taken. IT is not met as evidenced of the incident of the incide				
	s the Willful Infliction (02-59) Previous Versions (of Injury, unreasonable	Fec	TITY ID: TN6006 If continue	ation sheet Page 5 of	

08/08/2017 11:51 NHC - MRTCC				(FAX)931 840) 4402 CIVID I	P.010/024
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL_RICLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		445030	B. WING			07/19/2017
NAME OF	PROVIDER OR SUPPLIER	Live in the second seco		STREET ADDRESS, CITY, STATE, ZI		
t MA	AURY REGIONAL TRA	NSITIONAL CARE CENTER		6010 TROTWOOD AVE COLUMBIA, TN 38401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 225	confinement, intimoresulting physical hanguishAn injury "injury of unknown stollowing conditions the injury was not of source of the injury patient; and (b) The of the extent of the injury or the number particular point in the over timeAll event neglect, or misapprovil be investigated alleged abuse, negligated of alleged abuse, negligated alleged abuse, negligated alleged abuse, negligated of alleged abuse, negligated of alleged abuse, negligated of alleged abuse, negligated alleged abuse, negligated of alleged abuse, negligated abuse, negligated of alleged abuse, negligated abuse	dation, or punishment with arm, paln, or mental should be classified as an source" when both of the are met: (a) The source of bserved by any person or the could not be explained by the injury is suspicious because injury or the location of the rof injuries observed at one ne or the Incidence of injuries is reported as possible abuse optiation of patient property to determine whether the ect, misappropriation of exploitation did or did not take trator or Director of Nurses rection of the investigation ged incident" Ilicy, Miscellaneous Special incies, Loss and or Diversion of 6/2016 revealed "All ected loss and/or diversion of ective of drug type or class, astigated and report pon the discovery or epancy, suspected loss of listrator, Director of Nursing Pharmacist and Director of ed and an investigation of the agencies, required by the notified" We revealed Resident #379 facility on 9/23/16 and with diagnoses including				
M CM9-25	37(02-89) Previous Versions 0	Obsolete Event ID: 788Z1	1 Fac	Hity ID: TN6005	if continuation s	heet Page 6 of 11

INTERMENT OF DEFICIENCIES (NO PLAN OF CORRECTION NO PLAN OF CORRECTION NO PLAN OF CORRECTION A BUILDING. 446030 A BUILDING. A BUILDING. A BUILDING. BY MAKE OF PROVIDER OR SUPPLIER AMAURY REGIONAL TRANSITIONAL CARE CENTER O(4) ID SUMMARY SYSTEMENT OF DEFICIENCIES (PARCECES) BY TUIL REGISTRANCH OR ALL DEPARTMENT OF DEFICIENCIES (PARCECES) BY TUIL REGISTRANCH OR ALL DEPARTMENT OF DEFICIENCIES (PARCECES) BY TUIL REGISTRANCH OR ALL DEPARTMENT OF DEFICIENCIES (PARCECES) BY TUIL REGISTRANCH OR ALL DEPARTMENT OF THE PROPERTY OF THE PROPE	08	3/08/2017 11:51 NE	IC - MRTCC		(FAX)931 840 4402	P.011/024
NAME OF PROVIDER OR SUPPLIER MAURY REGIONAL TRANSITIONAL CARE CENTER MAURY REGIONAL TRANSITIONAL CARE CENTER CALIBRIA, 17 38401 PRESIX REGULATORY OR LSC IDENTIFYING INFORMATION) FREDULATORY OR LSC IDENTIFYING INFORMATION) FREDULATORY OR LSC IDENTIFYING INFORMATION) FREDULATORY OR LSC IDENTIFYING INFORMATION) F 225 Continued From page 8 Dementla, and Obstructive Sleep Apnea. Medical record review of the 14 day Minimum Data Set (MDS) dated 10/10/16 revealed Resident #379 ecutred review of the MDS revealed Resident S4379 equited extensive assistance of 2 people for transfers and tolleting; extensive assistance of 1 person for dressing and batching; assistance of 1 person for dressing and batching; assistance of 1 person for grooming; supervision for eating; and was frequently incontinent of bowel and bladder. Medical record review of nursing notes dated 10/28/16 revealed Resident #379 had bilateral upper extremity skin tears. Continued review of nursing notes dated 11/4/16 revealed the resident had multiple skin tears to bilateral upper extremities. Review of incident reports revealed none were completed for these injuries of unknown origin. Interview with the Director of Nursing (DON) on 7/19/17 at 4:30 PM in the conference room, confirmed there were no incident reports for the skin tears which occurred on 10/28/17 and 11/4/17, Continued interview with the DON confirmed there was no investigation into either liquing of unknown origin. Medical record review revealed Resident #188 was admitted to the facility on 7/19/16 with diagnosee including Vascular Dementia with				1	PLE CONSTRUCTION	(X3) DATE SURVEY
NAME OF PROVIDER OR SUPPLIER MAURY REGIONAL TRANSITIONAL CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH) DEFICIENCIES (EACH) DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FACE DEPICE OF THE APPOPRIATE DEFICIENCY COLUMBIA, TN 38491 PROVIDERS PLAN OF CORRECTION POSSIBLE PREFIX TAG (CACHE CENTRO PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPOPRIATE DEFICIENCY) FOR DEPICE OF THE APPOPRIATE DEFICIENCY FOR DEPICE OF THE APPOPRIATE DEFICIENCY FOR DEFICIENCY			445030	B, WING	w.	07/19/2017
F 225 Continued From page 8 Dementia, and Obstructive Sleep Apnea. Medical record review of transfers and tolleting; supervision for designant of transfers and tolleting; supervision for earling; and was frequently incontinent of bowel and bladder. Medical record review of fursing notes dated 10/28/16 revealed Resident 13/39 had bilateral upper extremities. Review of incident reports revealed none were completed for multiple injuries of unknown origin. Interview with the Director of Nursing (DON) on 7/19/17 at 4:30 PM in the conference room, confirmed there were no incident resports for the skin tears which cocurred on 10/28/17 and 11/4/17. Confirmed there was no investigation into either injury of unknown origin. Medical record review with the DON confirmed there was no investigation into either injury of unknown origin. Medical record review with the DON confirmed there was no investigation into either injury of unknown origin.			NSITIONAL CARE CENTER		5010 TROTWOOD AVE	
Dementia, and Obstructive Sleep Apnea. Medical record review of the 14 day Minimum Data Set (MDS) dated 10/10/16 revealed Resident #379 scored 15/15 on the Brief Interview for Mental Status, Indicating she was alert and oriented. Continued review of the MDS revealed Resident #379 required extensive assistance of 2 people for transfers and folieting; extensive assistance of 1 person for dressing and bathing; assistance of 1 person for dressing and bathing; assistance of 1 person for or dressing and bathing; assistance of 1 person for or dressing and bathing; assistance of 1 person for dressing and bathing; assistance	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE COMPLETION
Behavioral Disturbance, Aphasia following Cerebral Infarction, Attention and Concentration	C	Dementia, and Obsi Medical record revision Data Set (MDS) data Resident #379 score Interview for Mental alert and oriented. Or revealed Resident # assistance of 2 peopextensive assistance bathing; assistance supervision for eating incontinent of bowel Medical record review 10/28/16 revealed Rupper extremity sking nursing notes dated had multiple sking teat extremities. Review of incident recompleted for these were completed for these were completed for the reconfirmed there were sking tears which occuping the medical record review was admitted to the finding of the person of the person of the person of the medical record review was admitted to the finding of the person of the p	tructive Sleep Apnea. Ew of the 14 day Minimum ed 10/10/16 revealed ed 15/15 on the Brief Status, Indicating she was continued review of the MDS 379 required extensive ble for transfers and tolleting; a of 1 person for dressing and of 1 person for grooming; g; and was frequently and bladder. Ew of nursing notes dated esident #379 had bilateral tears. Continued review of 11/4/16 revealed the resident ters to bilateral upper Exports revealed none were injuries and no investigations multiple injuries of unknown Fector of Nursing (DON) on the conference room, eno incident reports for the urred on 10/28/17 and aterview with the DON no investigation into either gin. Ev revealed Resident #168 acility on 7/19/16 with //ascular Dementia with ce, Aphasia following	F 226		

08	08/2017 11:51 NH	C - MRTCC		(FAX)931 840 4402	OMID 140	P.012/024
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		445030	B. WING	A COURT	07	/19/2017
	PROVIDER OR SUPPLIER LURY REGIONAL TRAI	NSITIONAL CARE CENTER	5	TREET ADDRESS, CITY, STATE, ZIP COD 010 TROTWOOD AVE COLUMBIA, TN 38401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	Deficit, Dysphagia, A Hypertension, Difficiand Contracture of Medical record reviet dated 4/18/17 revealed 1/18/17 revealed 1/18/17 at 8:50 AM Frevealed 1/18/17	Anxiety, Depression, ulty in Walking, Chronic Pain, Right Knee. We of the Quarterly MDS aled a Brief Interview for not be conducted because winever understood. We of a nurse note dated by Registered Nurse (RN) #1 of fentanyl patch [narcotic pain mal patch] to R [right] chest ask on coming nurse to none found, to place another I on 7/19/17 at 2:25 PM via she worked the 7PM to 7AM 7/17 and cared for Resident ew revealed she checked the ntanyl patch around 4 AM Continued interview revealed missing Fentanyl patch to urse (LPN) #1 at shift er to get it replaced if it I unit Manager on 7/19/17 at rence room, when asked her staff should notify her of a ch on a resident revealed be notified immediately. The revealed she was notified of patch for Resident #168 at on this date by LPN #2.	F 225			
		N on 7/19/17 at 4:38 PM in revealed she did not find out		IN THEODE IF COD	r	t Page 8 of 11

08	/08/201711:52 NH	C - MRTCC		(FAX)931 840 4402	P.013/024
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPR/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		445030	B. WING		07/19/2017
_	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 5010 TROTWOOD AVE	
;-M/	AURY REGIONAL TRAI	NSITIONAL CARE CENTER		COLUMBIA, TN 38401	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	about the missing F morning, and an invinitiated. Continued not report the missir supervisor or the DO the incident had not agency. Continued it confirmed RN #1 did misappropriation of timely manner and tistate Agency in the 483.70(I)(1)(5) RES	ge 8 entanyl patch until this estigation had since been interview revealed RN #1 did ng Fentanyl patch to the unit DN. Further interview revealed been reported to the state interview with the DON is not report the possible narcotic medication in a the facility did not report to the required time period. ETE/ACCURATE/ACCESSIB	F 225	F514	
SS≃D	(I) Medical records. (1) In accordance will standards and practi	th accepted professional		Record corrected on Patient #168 DON reviewed MAR for all patients on pain patches to ensure accurate documentation	8/1/17 8/1/17
	(i) Complete;				
	(ii) Accurately docum			Regional nurse to in-service nurses on accurate documentation regarding missing pain patch	8/8/ 17
	(iv) Systematically or	ganized			
	(5) The medical reco	rd must contain-		DON/Team Coordinator or pharmacy consultant will QA 2 patients on fentan	างโ
	(i) Sufficient informati	on to Identify the resident;		patches for any evidence of	·J*
	(II) A record of the res	sident's assessments;	į.	misappropriation and to ensure MD/DON is notified when appropriate	
	(iii) The comprehensl provided;	ve plan of care and services	é	Weekly x 4 weeks, then monthly x3, the quarterly or until substantial compliance is met	ie n
M CMS-256	7(02-98) Previous Versions Ob	psolete Event ID: 788Z11	Fac	illy ID: TN8008 If continuation sho	eet Page 9 of 11

08/08/2017 11:52 NHC - MRTCC CENTERS FOR MEDICARE & MEDICARD SE /ICES			(FAX)931 840 4402 P.014/024					
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPFLICR/CLIA IDENTIFICATION NUMBER:	To the second		E CONSTRUCTION	(X3) DA	ATE SUF	RVEY
		445030	B. WING			0;	7)19/2	:017
NAME OF	PROVIDER OR SUPPLIER	1			TREET ADDRESS, CITY, STATE, ZIP CODE			
(:-MA	URY REGIONAL TRA	NSITIONAL CARE CENTER			OLUMBIA, TN 38401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE		(X5) APLETION DATE
	(iv) The results of a and resident review determinations con (v) Physician's, nur professional's prog (vi) Laboratory, rad services reports as This REQUIREMENT by: Based on medical the facility failed to Medication Administresident (#168) of 32 for accurate document of the findings included Medical record reviewas admitted to the diagnoses including Behavioral Disturbation, Deficit, Dysphagia, Hypertension, Difficiand Contracture of the Medical review of the Set dated 4/18/17 refered to the diagnoses including Behavioral Disturbation, Deficit, Dysphagia, Hypertension, Difficiand Contracture of the Medical review of the Set dated 4/18/17 refered to the diagnose including the resident is rarely Medical record reviewed the resident is rarely Medical record reviewed in the patch was "not fit in the patch was "not fi	any preadmission screening viewaluations and aducted by the State; se's, and other licensed ress notes; and lology and other diagnostic required under §483.50. NT is not met as evidenced record review and interview accurately document on the stration Record (MAR) for one 55 residents reviewed in stage mentation. ed: ew revealed Resident #168 facility on 7/19/16 with a Vascular Dementla with ance, Aphasia following Attention and Concentration Anxiety, Depression, ulty in Walking, Chronic Pain, Right Knee. e Quarterly Minimum Data evealed a Brief Interview for not be conducted because not the market on the night shift on lew revealed documentation be not be night shift on lew revealed documentation lew revealed documentation						
RM CMS-258	7/02-99) Previous Versions (Obsolete Event ID: 768Z1	1	Facili	ty ID: TN8008 If contin	uation sheel	Page	10 of 11

08/	08/2017 11:52 NHC	- MRTCC		(FAX)931 840 4402	OMD IAC	P.015/024
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUI _R/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		445030	B. WING		07	/19/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		71012017
(F-MA	URY REGIONAL TRAI	NSITIONAL CARE CENTER		COLUMBIA, TN 38401		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X6) COMPLETION DATE
F 514	1	ge 10 t on 7/18/17 as "RT AC" (right	F 514			
	Interview with Licens on 7/19/17 at 2:55 P did the resident have pain medication tran 7/18/17 stated "she interview when aske checking the patch on 7/18/17 states is should have put no revealed LPN #1 states about LPN #1's document the DON confirmaccurately document at 2:38 PM in the context of the contex	7 day shift for Resident #168.		the IDs Thisping If continue		Page 11 of 13